B. Adjust item A for case mix according to subitems (1) to (4).

(1) Multiply the hospital's number of outlier days by program and specialty group within each diagnostic category by the relative value of that diagnostic category.

(2) Add the products determined in subitem (1).

(3) Divide the total from subitem (2) by the number of hospital outlier days.

(4) Divide the cost per day outlier as determined in item A by the quotient calculated in subitem (3) and round that amount to whole dollars.

5.03 Out-of-area hospitals. The Department determines the adjusted base year operating cost per admission and per day outlier by program and specialty group according to items A to C.

A. Multiply each adjusted base year operating cost per admission and per day outlier in effect on the first day of a rate year for each Minnesota and local trade area hospital by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all the hospitals and round that amount to whole dollars.

5.04 Minnesota MSA and local trade area hospitals that do not have Medical Assistance admissions or day outliers in the base year and MSA hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota. The Department determines the adjusted base year operating cost per admission or per day outlier by program and specialty group according to items A to C.

A. Multiply each adjusted base year cost per admission and day outlier in effect on the first day of a rate year for each Minnesota MSA and local trade area hospital by the number of corresponding admissions or outlier days in that hospital's base year.

B. Add the products calculated in item A.

C. Divide the total from item B by the total admissions or outlier days for all Minnesota MSA and local trade area hospitals and round that amount to whole dollars.

5.05 Non-MSA hospitals that do not have Medical Assistance admissions or day outliers in the base year. The Department determines the adjusted base year operating cost per admission or per day outlier by program and specialty group for non-MSA hospitals by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under §5.04.

5.06 Limitation on separate payment and outlier percentage. Hospitals that have rates established under §5.03 may not have certified registered nurse anesthetists services paid separately and hospitals that have rates established under §5.03, §5.04, or §5.05 may not elect an alternative outlier percentage.

6.0 DETERMINATION OF ADJUSTED BASE YEAR OPERATING COST PER DAY

6.01 Neonatal transfers For Minnesota and local trade area hospitals, the Department determines the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a neonatal intensive care unit (NICU) according to subitems (1) to (3).

(1) Determine the operating cost per day for each diagnostic category as defined at §2.0, item D according to §4.01, items A to F, except that the ratios in item E, subitem (2), will be adjusted to exclude certified registered nurse anesthetist costs and charges if separate billing for these services is elected, and divide the total base year operating costs by the total corresponding inpatient hospital days for each admission.

(2) Determine relative values for each diagnostic category at §2.0, item D, according to §4.01, items G, H, and I, after substituting the term "day" for "admission."

(3) Adjust the result of subitem (2) according to §5.01, subitem D, after substituting the term "day" for "admission."

6.02 Minnesota MSA and local trade area hospitals that do not have Medical Assistance neonatal transfer admissions in the base year. The Department determines the neonatal transfer adjusted base year operating cost per day for admissions that result from a transfer to a NICU according to subitems (1) to (3).

(1) Multiply each adjusted base year cost per day in effect on the first day of a rate year for each Minnesota MSA and local trade area hospital by the number of corresponding days in the hospital's base year.

(2) Add the products in subitem (1).

(3) Divide the total from subitem (2) by the total days for all Minnesota MSA and local trade area hospitals and round that amount to whole dollars.

6.03 Non-MSA hospitals that do not have Medical Assistance neonatal transfer admissions in the base year. The Department determines the adjusted base year operating cost per day for admissions that result from a transfer to a NICU by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under §6.02.

6.04 Long-term hospital. The Department determines the base year operating cost per day for hospital admissions to Minnesota and MSA long-term hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota as designated by Medicare for the rate year according to items A and B.

A. Determine the operating cost per day according to §4.01, items A to E, except that claims excluded in §4.01, item B, subitems (2) and (4), will be included and the ratios in §4.01, item E, subitem (2), will be adjusted to exclude certified registered nurse, anesthetist costs and charges if separate billing for these services is elected.

B. Divide the total base year operating costs for all admissions in item A by the total corresponding inpatient hospital days for all admissions and round that amount to whole dollars.

6.05 Minnesota and MSA long-term hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota that do not have Medical Assistance admissions in the base year. The Department determines the operating cost per day according to items A to C.

A. Multiply each operating cost per day in effect on the first day of a rate year for each Minnesota and local trade area long-term hospital by the number of corresponding days in that hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total days for all long-term hospitals and round that amount to whole dollars.

7.0 DETERMINATION OF HOSPITAL COST INDEX (HCI)

7.01 Adoption of HCI. The most recent *Health Care Costs* published by Data Resources Incorporated (DRI) is used.

7.02 Determination of HCI. For the period from the midpoint of each hospital's base year to the midpoint of the rate year, or, when the base year is not rebased, from the midpoint of the prior rate year to the midpoint of the current rate year, the Department determines the HCI according to items A to G.

A. The Department obtains from DRI the average annual historical and projected cost change estimates in a decimal format for the operating costs in subitems (1) to (7):

(1) Wages and salaries.

(2) Employee benefits.

(3) Medical and professional fees.

(4) Raw food.

(5) Utilities.

(6) Insurance including malpractice.

(7) Other operating costs.

B. Obtain data for operating costs of hospitals in Minnesota which indicate the proportion of operating costs attributable to item A, subitems (1) to (7).

C. For each category in item A, multiply the amount determined in item B by the applicable amount determined in item A.

D. Add the products determined in item C and limit this amount to the statutory maximums on the rate of increase. Round the result to three decimal places.

E. For the period beginning October 1, 1992, through June 30, 1993, add 0.01 to the index in item D.

F. ~~Effective for~~ Beginning with the 1997 rate year, the HCI from the prior rate year to the current rate year is the change in the Consumer Price Index-All Items (United States city average) (CPI-U) as forecasted by DRI in the third quarter of that prior rate year to the current rate year.

G. The 2000 rate year HCI is reduced .025 for payments of inpatient hospital services provided in that year. The HCI before the .025 reduction will be used in the determination of the HCI for subsequent rate years.

H. Add one to the amounts calculated in items E and F and multiply these amounts together. Round the result to three decimal places.

8.0 DETERMINATION OF PROPERTY COST PER ADMISSION

8.01 Minnesota and local trade area hospitals. The Department determines the property cost per admission for each Minnesota and local trade area hospital according to items A to D.

A. Determine the property cost for each hospital admission in §4.01, item D using each hospital's base year data according to subitems (1) to (4).

(1) Multiply the number of accommodation service inpatient days by that accommodation service property per diem and add the products.

(2) Multiply each ancillary charge by that ancillary property cost to charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the results of subitem (3) for all admissions for each hospital.

B. Determine the property cost for each hospital admission in §4.01, item D using each hospital's base year data and recent year Medicare cost report data that was submitted by the October 1 prior to a rebased rate year according to subitems (1) to (4).

(1) Multiply the base year number of accommodation service inpatient days by that same recent year accommodation service property per diem and add the products.

(2) Multiply each base year ancillary charge by that annualized recent year property cost to base year charge ratio and add the products.

(3) Add subitems (1) and (2).

(4) Add the totals of subitem (3) for all admissions for each hospital.

C. Determine the change in the property cost according to subitems (1) to (3).

(1) Subtract item A, subitem (4) from item B, subitem (4), and, if positive, divide the result by item A, subitem (4).

(2) Multiply the quotient of subitem (1) by 0.85.

(3) Add one to the result of subitem (2) and round to two decimal places.

D. Determine the property cost per admission by program and specialty group according to subitems (1) to (3).

(1) Assign each admission and property cost in item A, subitem (3) to the appropriate diagnostic category program and specialty group.

(2) Multiply the cost of each admission in subitem (1) by the factor in item C, subitem (3).

(3) Add the products within each group in subitem (2), divide the total by the number of corresponding admissions, and round the resulting amount to whole dollars.

8.02 Out-of-area hospitals. The Department determines the property cost per admission by program according to items A to C.

A. Multiply each property cost per admission in effect on the first day of a rate year for each Minnesota and local trade area hospital by the number of corresponding admissions in that hospital's base year.

B. Add the products in item A.

C. Divide the total from B by the total admissions for all the hospitals and round the resulting amount to whole dollars.

8.03 Minnesota MSA and local trade area hospitals that do not have Medical Assistance admissions in the base year and MSA hospitals located in a state other than Minnesota, bu in a county of the other state in which the county is contiguous to Minnesota. The Department determines the property cost per admission by program and specialty group according to items A to C.

A. Multiply each property cost per admission in effect on the first day of a rate year for each Minnesota and local trade area MSA hospital by the number of corresponding admissions in the hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total admissions for all MSA hospitals and round the resulting amount to whole dollars.

8.04 Non-MSA hospitals that do not have Medical Assistance admissions in the base year. The Department determines the property cost per admission by program and specialty group by substituting non-MSA hospitals terms and data for the Minnesota MSA and local trade area hospitals terms and data under §8.03.

9.0 DETERMINATION OF PROPERTY COST PER DAY

9.01 Neonatal transfers. For Minnesota and local trade area hospitals, the Department will determine the property cost per day for neonatal transfer admissions that result from a transfer to a NICU according to §8.01, item D, after substituting the term "day" for "admission."

For Minnesota and local trade area hospitals that do not have Medical Assistance neonatal transfer admissions in the base year, the Department will determine the neonatal transfer property cost per day for admissions in the base year according to §8.03 after substituting the term "day" for "admission."

9.02 Long-term hospitals. For long-term hospitals, the Department determines the property cost per day for hospital admissions to Minnesota and MSA long-term hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota as designated by Medicare according to §9.01, except that claims excluded in §4.01, item B, subitems (2) and (4) will be included.

For Minnesota and MSA long-term hospitals located in a state other than Minnesota, but in a county of the other state in which the county is contiguous to Minnesota that do not have Medical Assistance admissions in the base year, the Department determines the property cost per day according to items A to C.

A. Multiply each property cost per day in effect on the first day of a rate year for each Minnesota and local trade area long-term hospital by the number of corresponding days in that long-term hospital's base year.

B. Add the products in item A.

C. Divide the total of item B by the total days for all the long-term hospitals, and round the resulting amount to whole dollars.

10.0 DETERMINATION OF RATE PER ADMISSION AND PER DAY

10.01 Rate per admission. The Department determines the rate per admission for Minnesota and local trade area hospitals as follows:

The payment rates are based on the rates in effect on the date of admission except when the inpatient admission includes both the first day of the rate year and the preceding July 1. In this case, the adjusted base year operating cost on the admission date shall be increased each rate year by the rate year HCI.

Rate Per Admission = [{(Adjusted base year operating cost per admission multiplied by the relative value of the diagnostic category) plus the property cost per admission) and multiplied by the disproportionate population adjustment and multiplied by small, rural payment adjustment multiplied by hospital payment adjustment multiplied by core hospital adjustment} plus rebasing adjustment]

10.02 Rate per day outlier. The day outlier rates are in addition to the rate per admission and will be determined by program or specialty group as follows:

A. The rate per day for day outliers is determined as follows:

Outlier Rate Per Day = {Adjusted base year operating cost per day outlier multiplied by the relative value of the diagnostic category and multiplied by the disproportionate population adjustment and multiplied by small, rural payment adjustment multiplied by hospital payment adjustment multiplied by core hospital adjustment}

B. The days of outlier status begin after the trim point for the appropriate diagnostic category and continue for the number of days a patient receives covered inpatient hospital services.

10.03 Transfer rate. Except for admissions subject to §10.04, a transfer rate per day for both the hospital that transfers a patient and the hospital that admits the patient who is transferred will be determined as follows:

Transfer Rate = Rate Per Day {(The rate per admission in item A, below, divided by the arithmetic mean length of stay of the diagnostic category) plus rebasing adjustment}

A. A hospital will not receive a transfer payment that exceeds the hospital's applicable rate per admission unless that admission is a day outlier.
B. Except as applicable under §12.4, rehabilitation hospitals and rehabilitation distinct parts are exempt from a transfer payment.

10.04 Rate per day.

A. Admissions resulting from a transfer to a NICU and classified to a diagnostic category of §2.0, item D will have rates determined according to §10.01 after substituting the word "day" for "admission."

B. Admissions for patients that are not transfers under §10.04, item A and are equal to or greater than the age of one at the time of admission and are classified to diagnostic categories KK1 through NN3 of §2.0, items A and B with a length of stay less than 50 percent of the mean length of stay for its diagnostic category under §4.01, item J, will be paid according to §10.03.

C. Admissions or transfers to a long-term hospital as designated by Medicare for the rate year will have rates determined according to §10.01 after substituting the word "day" for "admission."

10.05 Neonatal respiratory distress syndrome. For admissions to be paid under diagnostic category KK5 of §2.0, items A and B, inpatient hospital services must be provided in either a level II or level III nursery. Otherwise, payment will be determined by taking into account respiratory distress but not respiratory distress syndrome.

11.0 RECAPTURE OF DEPRECIATION

11.01 Recapture of depreciation. The Department determines the recapture of depreciation due to a change in the ownership of a hospital that is to be apportioned to Medical Assistance, using methods and principles consistent with those used by Medicare to determine and apportion the recapture of depreciation.

11.02 Payment of recapture of depreciation. A hospital shall pay the Department the recapture of depreciation within 60 days of written notification from the Department.

Interest charges must be assessed on the recapture of depreciation due the Department outstanding after the deadline. The annual interest rate charged must be the rate charged by the Department of Revenue for late payment of taxes in effect on the 61st day after the written notification.

12.0 PAYMENT PROCEDURES

12.1 Submittal of claims. Hospital billings under the Medical Assistance program cannot be submitted until the recipient is discharged. However, the Department establishes monthly interim payments for hospitals that have recipient lengths of stay over 30 days regardless of the diagnostic category.

12.2 Payment for readmissions. An admission and readmission to the same or a different hospital within 15 days, not including the day of admission and the day of discharge, is eligible for payment according to criteria that determines whether the admission and readmission are paid as one admission, two admissions or as transfers. (Outlier payments are paid when applicable.)

A. An admission and readmission are paid as two admissions when the recipient's discharge from the first admission and subsequent readmission are medically appropriate according to prevailing medical standards, practice and usage. An admission and readmission are also paid as two admissions when the reason for the readmission is the result of:

(1) A recipient leaving the hospital of the first admission against medical advice;

(2) A recipient being noncompliant with medical advice that is documented in the recipient's medical record as being given to the recipient; or

(3) A recipient having a new episode of an illness or condition.

B. An admission and readmission are paid as a combined admission if they occur at the same hospital, or as transfer payments if they occur at different hospitals, when a recipient is discharged from the first admission without receiving medically necessary treatment because of:

(1) Hospital or physician scheduling conflict;

(2) Hospital or physician preference other than medical necessity;